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Supreme Court of the United States

WHOLE WOMAN'S HEALTH, *et al.*,

Petitioners,

v.

KIRK COLE, COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF TWELVE ORGANIZATIONS DEDICATED TO THE FIGHT FOR REPRODUCTIVE JUSTICE AS *AMICI CURIAE* SUPPORTING PETITIONERS

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS i

TABLE OF CITED AUTHORITIES iv

INTEREST OF *AMICI* 1

STATEMENT AND SUMMARY OF ARGUMENT .. 2

ARGUMENT 5

I. BINDING PRECEDENT PROHIBITS ABORTION REGULATIONS THAT IMPOSE A SUBSTANTIAL OBSTACLE FOR MANY WOMEN 5

A. The Constitution Prohibits States From Passing Laws That Pose An "Undue Burden" On A Woman's Right To Choose To Terminate A Pregnancy 5

B. Abortion Restrictions Pose An Undue Burden If They Impose A Substantial Obstacle On A Significant Number Of Women Seeking An Abortion 6

C. African-American Women Comprise A Significant Number Of Women Who Seek Abortions And Other Healthcare Services From The Clinics Affected By The Challenged H.B. 2 Provisions 7

Table of Contents

Page

II. AFRICAN-AMERICAN WOMEN FACE SIGNIFICANT BARRIERS IN OBTAINING REPRODUCTIVE HEALTHCARE, INCLUDING ABORTION SERVICES 8

A. African-American Women Lack Access To Contraception And, As A Result, Have Higher Incidence Of Unintended Pregnancies 8

B. African-American Women Have Inferior Access To Prenatal Care And Are At Higher Risk For Pregnancy-Related Complications 12

C. African-American Women Lack Access To Health Screenings And Education And Suffer Higher Incidences Of STIs And Cancer 14

III. THE CHALLENGED H.B. 2 PROVISIONS IMPOSE AN UNDUE BURDEN ON AFRICAN-AMERICAN WOMEN 16

A. Clinic Closures Caused By The Challenged H.B. 2 Provisions Will Further Limit Women's Access To Abortion 16

Table of Contents

Page

B. A Significant Number Of African-American Women Will Be Unable To Overcome The Substantial Obstacles Imposed By The Challenged H.B. 2 Provisions.....20

C. Clinic Closures Will Also Deprive African-American Women Of Critical Reproductive Health Services.....23

CONCLUSION 25

APPENDIX.....1a

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Page

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INTEREST OF *AMICI*

Amici are[1] 12 organizations dedicated to the fight for a woman's right to control her body, sexuality, gender, work, and reproduction ("Reproductive Justice"), particularly on behalf of underserved or at-risk communities, including African-American women. This brief focuses on the devastating impact the challenged provisions of Texas House Bill 2, 83rd Leg., 2nd Called Sess. (Tex. 2013) ("H.B. 2") (the "Challenged H.B. 2 Provisions") will have on African-American women in Texas.

Through their advocacy for Reproductive Justice, *Amici* are acutely aware of the myriad barriers African-American women face in accessing quality reproductive healthcare and the inferior health outcomes they experience as a result. African-American women and other communities of women in Texas who have long suffered inequality of access to reproductive healthcare are among those most likely to be affected by the Challenged H.B. 2 Provisions. For these women, there can be no doubt that the Challenged H.B. 2 Provisions, and the resulting dramatic reduction in availability of reproductive health services in Texas, will impose an undue burden on their ability to obtain a safe and legal abortion.

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1. Pursuant to Rules 37.3 and 37.6 of the Rules of the Supreme Court, all parties have consented to the filing of this *amici curiae* brief. No counsel for a party authored this brief in whole or in part, and no counsel for a party made any monetary contribution to fund the preparation or submission of this brief. In addition, no persons or entities other than *amici* or their counsel made a monetary contribution to the preparation or submission of the brief.

The *Amici* are identified individually in the annexed Appendix.

STATEMENT AND SUMMARY OF ARGUMENT

Every woman has the right to make fundamental decisions concerning her body, sexuality, and reproductive health. There are many reasons, both personal and medical, why a woman might decide to terminate a pregnancy. Only the woman seeking an abortion can fully understand the complex factors informing that decision. Despite the intensely personal factors that may motivate a woman to obtain an abortion, there are many forms of oppression—economic, social, and political—that prevent women from exercising that constitutional right.

African-American women in particular have been systematically denied the resources, services, and information they need to make these important and personal health decisions. The consequences for African-American women have been profound: they are disproportionately likely to become pregnant unintentionally, to experience pregnancy-related health complications, and to become gravely ill or die in childbirth.

With the enactment of H.B. 2, Texas erected a series of barriers that, by design or impact, unlawfully interfere with women's constitutionally protected right to terminate a pregnancy. H.B. 2 is an omnibus abortion bill that requires, *inter alia*, that all doctors performing abortion procedures have admitting privileges at a hospital located within 30 miles of the clinics at which they perform abortions and that each abortion clinic within the state qualify as an ambulatory surgical center ("ASC"). While

these types of restrictions, which are known as targeted regulation of abortion providers or "TRAP" laws, are passed for the ostensible purpose of protecting women's health, in practice, they have the opposite effect. Leaving aside that the rate of serious health complications arising from abortion procedures has been found to be less than 0.25%[2]—a fact that, by itself, suggests these sorts of onerous restrictions are unnecessary—TRAP laws close clinics, make abortions significantly more difficult and expensive to obtain, and thus increase (rather than decrease) the risks to women's health. These laws have gained political traction since 2010 and have been enacted in at least 26 states. *See Targeted Regulation of Abortion Providers*, NARAL: PRO-CHOICE AMERICA, http://www.prochoiceamerica.org/what-is-choice/fast-facts/issues-trap.html (last visited Dec. 29, 2015). In the last five years, TRAP regulations have been the subject of numerous legal challenges, including the present action. *See, e.g., Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015), *West Ala. Women's Ctr. v. Williamson*, No. 15cv497-MHT, 2015 WL 4873125 (M.D. Ala. Aug. 13, 2015).

H.B. 2 was allegedly enacted to provide women who choose to have an abortion with "the highest standard of healthcare" and to protect their "health and safety." Senate Comm. on Health & Human Servs., Bill Analysis, Tex. H.B. 2, 83d Leg., 2d C.S. 1 (2013). As with other TRAP

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2. A 2015 study analyzing data concerning women covered by the fee-for-service California Medicaid program who obtained an abortion in 2009 or 2010 found that major complications (requiring hospitalization, surgery, or a blood transfusion) occurred in 0.23% of cases. *See* Ushma D. Upadhyay *et al.*, *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175, 176, 181 (2015).

laws, however, the reality is far different. The Challenged H.B. 2 Provisions threaten to dramatically heighten the already significant barriers to obtaining quality reproductive healthcare faced by the more than 725,000 reproductive-aged African-American women living in Texas. *See Peristats, Population of women 15-44 years by race/ethnicity: Texas, 2013*, MARCH OF DIMES, http://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=48&top=14&stop=127&lev=1&slev=4&obj=3. Prior to enactment of H.B. 2, there were over 40 clinics providing reproductive healthcare services to women living in Texas, including abortion services. As of November 2015, only 19 of these clinics remain, a number that will dwindle to ten or fewer clinics if the Fifth Circuit's decision is affirmed. These clinic closures will significantly harm African-American women in Texas, not only by severely restricting their access to abortion services, but by depriving them of other critical reproductive health services that are routinely provided at these facilities and will no longer be available.

As Petitioners thoroughly detail in their brief, the dramatic reduction in the number of abortion clinics caused by the Challenged H.B. 2 Provisions is sure to result in increased wait times for appointments, longer distances for patients to travel, and significantly higher expenses. These new obstacles will compound barriers to reproductive healthcare already imposed by Texas law, which include a mandatory ultrasound and 24-hour waiting period. Indeed, given that economic hardships, inflexible employment schedules, and extensive family obligations are already facts of life for many African-American women who live in Texas, the Challenged H.B. 2 Provisions will make it all but impossible for a significant number of

them to exercise their constitutionally-protected right to a pre-viability abortion. The Challenged H.B. 2 Provisions therefore impose an undue burden on the ability of a significant number of Texas women to exercise their constitutional right to obtain a pre-viability abortion.

ARGUMENT

I. BINDING PRECEDENT PROHIBITS ABORTION REGULATIONS THAT IMPOSE A SUBSTANTIAL OBSTACLE FOR MANY WOMEN.

A. The Constitution Prohibits States From Passing Laws That Pose An "Undue Burden" On A Woman's Right To Choose To Terminate A Pregnancy.

The Constitution protects a woman's right to choose to terminate her pregnancy. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 869 (1992); *Roe v. Wade*, 410 U.S. 113, 153 (1973). While a state may seek to regulate abortion in order to advance legitimate governmental interests, laws regulating abortion must not impose an "undue burden" on a woman's ability to exercise her abortion right. *Casey*, 505 U.S. at 876. As this Court held in *Casey*, "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right." *Id.* at 878, 877 ("[A] finding of an undue burden is a shorthand for the conclusion that a state regulation . . . [is] a substantial obstacle."). *See also Gonzales v. Carhart*, 550 U.S. 124, 146 (2007) (A state "may not impose upon a [woman's right to terminate her pregnancy] an undue burden, which exists if a regulation's purpose or effect is to

place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability."); *Schimel*, 806 F.3d 908 at 921 (finding that a burden is undue when it is "excessive in relation to the aims of the statute and the benefits likely to be conferred by it").

B. Abortion Restrictions Pose An Undue Burden If They Impose A Substantial Obstacle On A Significant Number Of Women Seeking An Abortion.

In assessing whether an abortion regulation poses an "undue burden," the fact that some women will continue to have access to safe, legal abortion facilities and procedures is insufficient. To the contrary, as *Casey* makes clear, the burden imposed by an abortion regulation must *not* be measured based on the number of women seeking abortions. Instead, *Casey* requires that the regulation's impact be "judged by reference to those for whom it is an actual rather than an irrelevant restriction." 505 U.S. at 895, 894 (striking down spousal notification provision affecting fewer than 1% of Pennsylvania women seeking abortions). As this Court explained:

> [t]he analysis does not end with the one percent of women upon whom the statute operates; it begins there. Legislation is measured for consistency with the Constitution by its impact on those whose conduct it affects . . . . The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant.

Id. at 894. Thus, *Casey* requires the Court to focus on whether the Challenged H.B. 2 Provisions are likely to pose substantial obstacles for a "significant number" of the women who are actually affected by them. *See id.* at 893-894.

C. African-American Women Comprise A Significant Number Of Women Who Seek Abortions And Other Healthcare Services From The Clinics Affected By The Challenged H.B. 2 Provisions.

A significant number of the women seeking abortions and other reproductive healthcare services provided by the Texas clinics subject to H.B. 2 are African-American. African-American women are statistically more likely to lack adequate access to sex education and contraception. *See infra* Part II. A. As a consequence, they have experienced unintended pregnancy at a higher rate than women of any other ethnic or racial group and at a rate more than double that of non-Hispanic white women. *Unintended Pregnancy in the United States*, GUTTMACHER INSTITUTE 1 (July 2015), https://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.pdf (citing Lawrence B. Finer *et al.*, *Shifts in Intended and Unintended Pregnancies in the United States, 2001—2008*, 104 AM. J. OF PUB. HEALTH S43 (2014)). Indeed, as recently as 2012, approximately 25% of the abortions performed in Texas were obtained by African-American women—despite the fact that African-American women comprised only 13.1% of Texas women between the ages of 15 and 44. TEXAS DEP'T OF STATE HEALTH SERVICES, INDUCED TERMINATIONS OF PREGNANCY BY CTY. OF RESIDENCE AND RACE ETHNICITY TEXAS tbl. 35 (2013); MARCH OF DIMES, *supra*. These

African-American women are overwhelmingly dependent on the clinics subject to H.B. 2—including those clinics that have already closed—for abortion services and other reproductive healthcare. *See e.g., infra* Part III. C.

As set forth below, because of the numerous and substantial barriers faced by African-American women in obtaining essential reproductive healthcare services, including abortions, the Challenged H.B. 2 Provisions—and the closure of multiple clinics in Texas that will result—impose an undue burden on a significant number of women.

II. AFRICAN-AMERICAN WOMEN FACE SIGNIFICANT BARRIERS IN OBTAINING REPRODUCTIVE HEALTHCARE, INCLUDING ABORTION SERVICES.

Because of a history of discrimination, economic disadvantage, and other factors, African-American women have been denied access to necessary reproductive healthcare services disproportionately. The lack of access to healthcare has harmed African-American women in numerous, measurable, and profound ways.

A. African-American Women Lack Access To Contraception And, As A Result, Have Higher Incidence Of Unintended Pregnancies.

Access to contraception is fundamental to a woman's ability to protect her reproductive health and prevent unintended pregnancy. Effective contraception and avoidance of unintended pregnancy enables women to attain higher education, remain employed, and establish

financial stability. *See* Sadia Haider *et al.*, *Reproductive Health Disparities: A Focus on Family Planning and Prevention Among Minority Women and Adolescents*, 2 GLOB. ADV HEALTH MED. 94 (2013). Despite the critical role contraception plays in women's success and financial stability, contraception use is uneven across segments of women. *Id.* Studies have shown that a lower percentage of African-American women who are sexually active and do not want to become pregnant use contraception than similarly-situated non-Hispanic white women. *Id.* (citing William D. Mosher *et al.*, *Use of Contraception in the United States: 1982–2008*, 23 VITAL HEALTH STAT. (2010)); *see also* Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 GUTTMACHER POL'Y REV. 2, 3 (2008). As a result, African-American women have suffered higher rates of unintended pregnancies, including adolescent African-American women who, as one study showed, were two to three times more likely to become pregnant than their non-Hispanic white peers. *See* Haider (2013), *supra*, at 94; Kathryn Kost & Stanley Henshaw, *U.S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends by Age, Race and Ethnicity*, GUTTMACHER INSTITUTE (May 2014), http://www.guttmacher.org/pubs/USTPtrends10.pdf. The same racial disparities are reflected in abortion rates, with African-American women experiencing abortions at a rate of 40.2 per 1,000 women in 2008 compared with 11.5 per every 1,000 non-Hispanic white women. *Id.*

A number of factors contribute to the limited access to contraception experienced by African-American women, including economic disparities and differences in social and historical contexts. *See* Zoe Dutton, *Abortion's Racial Gap*, THE ATLANTIC, (Sep. 22, 2014), http://www.

theatlantic.com/health/archive/2014/09/abortions-racial-gap/380251/. One factor contributing to lower rates of contraceptive use and higher unintended pregnancy rates among African-American women is lack of access to adequate reproductive health education. For instance, one study found that African-American adolescents receive less thorough education on reproductive health and birth control than their non-Hispanic white counterparts within the same income bracket. *See* Christine Dehlendorf *et al.*, *Disparities in Abortion Rates*, 103 AM. J. PUBLIC HEALTH 1772, 1774 (2013) (citing Joyce C. Abma *et al.*, *Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing*, 23 VITAL HEALTH STAT. (2010)). African-American women also have lower rates of contraception use because they often cannot afford to pay the often significant costs[3] associated with contraceptive services due to systemic economic inequality (*see infra* at Part III. B) and lower rates of health insurance (*see infra* Part III. C).

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3. A national survey found that one in three women have struggled to afford birth control at some point in their lives and, as a result, have used birth control inconsistently. *See* S. Con. 1532, 114 Cong. (2015). Another study found that the cost of contraceptives for women using them represented a significant portion (30-40%) of total out-of-pocket healthcare spending (before the implementation of the Affordable Care Act). *See* Nora V. Becker & Daniel Polsky, *Women Saw Large Decrease in Out-of-Pocket Spending For Contraceptives After ACA Mandate Removed Cost Sharing*, 34 HEALTH AFFAIRS 1204, 1208 (2015).

Although the Affordable Care Act's mandate that private health insurance plans cover prescription contraceptives with no consumer cost sharing has resulted in substantial out-of-pocket savings per contraceptive user, *see id.* at 1204, this relief is unavailable to the significant percentage of poor and uninsured women residing in Texas. *See infra* Part III. C.

While the inability of African-American women to access contraception persists nationwide, the problem has become particularly acute in Texas where public funding for contraception has markedly declined. Between 2001 and 2013, the number of women in Texas receiving publicly funded contraceptive services and supplies fell from 540,620 to 281,170, a decrease of 48%. Jennifer J. Frost *et al.*, *Contraceptive Needs and Services, 2013 Update*, GUTTMACHER INSTITUTE 26 (July 2015), http://www.guttmacher.org/pubs/win/contraceptive-needs-2013.pdf. Over nearly the same time period (2000-2013), the number of women in Texas in need[4] of publicly funded contraceptive services and supplies had grown by 26%. *See id.* at 14, 23 (attributing the increase in the number of women in need of publicly funded care to growing income disparities in the United States and the economic recession). Consequently, while 41% of the women in Texas in need of publicly funded contraceptive care in 2001 received those services, that figure had fallen to 16% by 2013. *Id.* at 28. This confluence of increased demand for publicly funded contraception and reduced public funding has put African-American women's access to contraception at even greater risk, particularly in Texas.

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4. The study defined women in need of publicly funded contraceptive services and supplies as women who were sexually active, physically able to conceive, not currently pregnant or trying to get pregnant, and either an adult with income under 250% of the federal poverty level or younger than 20 years of age. Frost *et al.*, (2015) *supra*, at 26.

B. African-American Women Have Inferior Access To Prenatal Care And Are At Higher Risk For Pregnancy-Related Complications.

African-American women are less likely than other women to have access to adequate prenatal care during pregnancy. In one study of women in Austin/Travis County, Texas, only 59% of African-American women received prenatal care in the first trimester, compared to 81% of non-Hispanic white women. MAMA SANA/VIBRANT WOMAN, AUSTIN—A "FAMILY-FRIENDLY" CITY: PERSPECTIVES AND SOLUTIONS FROM MOTHERS IN THE CITY 4 (2015). Likewise, African-American women suffer pregnancy-related health complications on a substantially greater per capita basis than any other racial or ethnic group. For example, a study found that African-American women had the highest rate of hypertensive disorders, such as preeclampsia and eclampsia, in pregnancy. Amani Nuru-Jeter *et al.*, *"It's The Skin You're In": African-American Women Talk About Their Experiences of Racism. An Exploratory Study to Develop Measures of Racism for Birth Outcome Studies*, 13 MATERN. CHILD HEALTH J. 1, 2 (2008).

African-American women were also more likely to deliver preterm and their children were more likely to have low birth weights. Indeed, one study surveying births in California between 2003 and 2010 found that the rate of preterm birth among African-American women was nearly double the rate of preterm birth among non-Hispanic white women (12.8% versus 7.4%). Paula A. Braveman *et al.*, *The Role of Socioeconomic Factors in Black-White Disparities in Preterm Birth*, 105 AM. J. OF PUB. HEALTH 694, 695 (2014). Similarly, the rate of low

birth weight[5] was much higher among infants born to African-American women (13.9%) compared with infants born to non-Hispanic white women (7.3%). CENTER FOR PUBLIC POLICY PRIORITIES, 2015 STATE OF TEXAS CHILDREN ANNUAL KIDS COUNT REPORT 9 (2015).

African-American women face significantly higher risks of maternal morbidity and mortality as well. Indeed, African-American women were three to four times more likely to die from pregnancy-related causes than non-Hispanic white women. *S.1696, The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights: Hearing Before the Committee on the Judiciary*, 113th Cong. 4 (2014) (testimony submitted for the record by the undersigned organizations). This disparity has increased since 2007. MAMA SANA/VIBRANT WOMAN, *supra* at 5. According to one study, for example, severe maternal morbidity[6] occurred more than twice as often in deliveries by African-American women as in deliveries by non-Hispanic white women. Elizabeth A. Howell *et al.*, *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 AM. J. OF OBSTETRICS AND GYNECOLOGY 122e.1, 122.e3 (2015). The same study found that rates of severe maternal morbidity

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5. The study defines low birth weight as less than 2,500 grams, or 5 pounds 8 ounces. *Id.* at 28.

6. The study used a published algorithm defined by investigators from the Centers for Disease Control and Prevention to identify "severe maternal morbidity," which is a potentially life-threatening diagnosis or receipt of a life-saving procedure (*e.g.* renal failure, shock, embolism, eclampsia, septicemia, mechanical ventilation, transfusion). Elizabeth A. Howell *et al.*, *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 AM. J. OF OBSTETRICS AND GYNECOLOGY 122e.1, 122.e2 (2015).

were significantly higher in hospitals that served the highest percentages of African-Americans. *Id.*

C. African-American Women Lack Access To Health Screenings And Education And Suffer Higher Incidences Of STIs And Cancer.

African-American women also suffer from insufficient access to critical health screenings and education and, thus, experience higher rates of sexually transmitted infections ("STIs") and cancer. African-American women were almost six times more likely to contract chlamydia and 11 times more likely to have gonorrhea than non-Hispanic white women in 2012. CENTERS FOR DISEASE CONTROL AND PREVENTION, 2014 SEXUALLY TRANSMITTED DISEASES SURVEILLANCE 66 (2015). African-American women were 20 times more likely than non-Hispanic white women to be infected with HIV, and one in 32 African-American women will be infected with HIV in their lifetime. *S.1696, The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights: Hearing Before the Committee on the Judiciary*, 113th Cong. 4 (2014) (testimony submitted for the record by the undersigned organizations).

Historically, African-American women were less likely to receive regular mammograms than non-Hispanic white women. Carol Smigal *et al.*, *Trends in Breast Cancer by Race and Ethnicity: Update 2006*, 56 CA CANCER J. CLIN. 168, 174, 178 (2006). Although it has been reported that mammography rates among both groups are now relatively even, studies indicate that African-American women experienced more delays in follow-up care following abnormal mammography results. *Id.* at 178;

Prethibha George *et al.*, *Diagnosis and Surgical Delays in African American and White Women with Early-Stage Breast Cancer*, 24 J. OF WOMEN'S HEALTH 209 (2015). Such delays are not without consequence. Studies show, for instance, that African-American women diagnosed with breast cancer suffered a 42% higher mortality rate. Carole E. DeSantis *et al.*, *Breast Cancer Statistics, 2015: Convergence of Incidence Rates Between Black and White Women*, 00 CA CANCER J. CLIN. 1 (2015).

African-American women were also twice as likely to die from cervical cancer than non-Hispanic white women. AM. CANCER SOCIETY, CANCER FACTS & FIGURES FOR AFRICAN AMERICANS: 2013-2014 12 (2013). This is in spite of the fact that cervical cancer is one of the most preventable and treatable forms of cancer: it can be prevented by the HPV vaccine or treated, if detected early by a regular Pap smear test. In a study conducted by the Center for Disease Control, non-Hispanic Black adolescent females completed the three-dose HPV vaccination series at a lower rate than non-Hispanic white adolescent females. Sarah Regan-Steiner *et al.*, *National, Regional, State, and Selected Local Area Vaccination Coverage Among Adolescents Aged 13-17 Years - United States, 2014*, 64 CTR. FOR DISEASE CONTROL AND PREVENTION: MORBIDITY AND MORTALITY WKLY. REP. 784, 788 (2015). The percentage of African-American women receiving regular Pap smear tests has declined from 85.1% in 2000 to 75.3% in 2013. CTR. FOR DISEASE CONTROL AND PREVENTION, 2014 SEXUALLY TRANSMITTED DISEASES SURVEILLANCE 66 (2015).

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The dramatic impact of the Challenged H.B. 2 Provisions on African-American women in Texas can only be understood in the context of this devastating history of pervasive inequality across nearly all aspects of reproductive healthcare.

III. THE CHALLENGED H.B. 2 PROVISIONS IMPOSE AN UNDUE BURDEN ON AFRICAN-AMERICAN WOMEN

A. Clinic Closures Caused By The Challenged H.B. 2 Provisions Will Further Limit Women's Access To Abortion.

As a result of the clinic closures caused by the Challenged H.B. 2 Provisions, women in Texas will face substantial obstacles to obtaining abortion services. As detailed in Petitioners' Brief, prior to the enactment of H.B. 2 more than 40 facilities in Texas provided abortions. *See* Pet'rs' Brief at 23. If the Fifth Circuit decision is affirmed, ten or fewer clinics will remain, clustered in four metropolitan areas: Dallas-Fort Worth, Austin, San Antonio, and Houston. *See id.* These closures will make abortion services more difficult to obtain in at least the following three respects.

First, women will have to wait longer to schedule an appointment with one of the few remaining abortion providers in Texas. A study by the Texas Policy Evaluation Project ("TxPEP") found that, since November 2014, wait times in the remaining abortion facilities were as long as 23 days. *Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics*, TEX. POLICY EVALUATION PROJECT (NOV.

25, 2015), https://utexas.box.com/AbortionWaitTimeBrief. Some clinics were completely unable to schedule appointments as a result of the volume of patients seeking services. *See id.*

Delays in obtaining abortion appointments are problematic from a public health perspective because, although still very safe, second-trimester abortion is associated with a higher risk of complications compared with first-trimester abortions. *Id.* at 6. The TxPEP study found that if the remaining non-ambulatory surgical center clinics close, the number of second-trimester abortions could increase from 10.5% to as much as 19.5% of all abortions performed in Texas. *Id.* at 5; *see also Schimel*, 806 F.3d at 918 ("[f]or the longer the waiting list for an abortion, the more women who want to have early-term abortions will perforce end up having later-terms ones, which are more dangerous."). Enduring longer waiting periods for obtaining an abortion not only has physiological implications; it may inflict psychological stress on women seeking to conceal an unintended pregnancy.[7]

Second, because the small number of clinics that will remain if the Fifth Circuit's decision is affirmed are clustered around four metropolitan areas, many Texas

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7. As this Court has previously recognized, women may have many reasons for concealing a pregnancy, even from her spouse. *See Casey*, 505 U.S. at 888 ("A wife may not elect to notify her husband of her intention to have an abortion for a variety of reasons, including the husband's illness, concern about her own health, the imminent failure of the marriage, or the husband's absolute opposition to the abortion."); *id.* at 889 ("Mere notification of pregnancy is frequently a flashpoint of domestic violence within the family.").

women seeking abortions will be required to travel substantially further distances to obtain them. Indeed, approximately 80% of women in Texas live outside of these four metropolitan areas. *See How Abortion Would Impact Five Areas of Texas*, THE TEX. POLICY EVALUATION PROJECT (Aug. 26, 2013), http://www.utexas.edu/cola/orgs/txpep/_files/pdf/TxPEP-HB2-Impact-Brief-26Aug2013.pdf. A study by TxPEP found the number of women living more than 50 miles from an abortion provider increased from 816,000 in May 2013 to 1,680,000 by April 2014. *See Access to Abortion Care in the Wake of HB2*, THE TEX. POLICY EVALUATION PROJECT (July 1, 2014), http://www.utexas.edu/cola/txpep/_files/pdf/AbortionAccessafterHB2.pdf. During the same time period, the number of women living more than 100 miles from a clinic providing abortion services increased from 417,000 to 1,020,000 and the number of women living more than 200 miles from such a clinic increased from 10,000 to 290,000. *Id.* If the ambulatory surgical center requirement goes into effect, as many as 1,960,000 women will be living more than 50 miles from a clinic; 1,335,000 women will live more than 100 miles from a clinic; and 752,000 women will live over 200 miles from a clinic.[8] *Id.; see also Whole Woman's*

8. At the time of the study, only five licensed abortion clinics were ASCs. *Id.* Although Petitioners now conservatively estimate that as many as ten abortion clinics could remain open after the ASC restrictions go into effect, the results of this study are still relevant given that four of the five additional clinics are within the same metropolitan areas as those contemplated in the study and the fifth clinic, the Whole Woman's Health of McAllen, would be extremely limited in its ability to provide abortions. *See* Pet'rs' Br. at 24, 26. The McAllen Clinic would be permitted to serve women in only four counties in the Lower Rio Grande Valley with only one doctor to provide such services. *See id.*

Health v. Lakey, 46 F. Supp. 3d 673, 681 (W.D. Tex. 2014) (finding since implementation of H.B. 2, women have faced significant travel distances to obtain abortion services and "[i]f not enjoined, the ambulatory-surgical-center requirement will further increase" the number of women who will need to travel significant distances to a clinic).

Third, the increased waiting periods for appointments and travel distances will have the additional effect of increasing the already substantial cost of obtaining an abortion. A 2013 study of women seeking abortions at six abortion providers across the United States between May and July 2011 found that a majority of women did not use health insurance to pay for their abortion. Rachel K. Jones *et al.*, *At What Cost? Payment for Abortion Care by U.S. Women*, 23 WOMEN'S HEALTH ISSUES e173, e178 (2013). On average, women (excluding the 21% of women who had no out-of-pocket expenses) paid approximately $485 for their abortions. *Id.* at e175. As discussed above, however, increased appointment wait times could result in more second-trimester abortions that, on average, cost substantially more ($854 average) than first-trimester procedures ($397 average). *Id.*

Women also incur substantial indirect expenses in obtaining abortions. For example, two-thirds of women surveyed in Women's Health Issues reported average transportation costs of $44; one quarter of women reported an average of $198 in lost wages, and approximately 10% reported average child-care expenses of $57. *Id.* at e176. Because the Challenged H.B. 2 Provisions will force many women to travel farther (and, thus, be away from work and children for longer periods) to obtain an abortion, these indirect expenses likely will increase. Texas law requires

that women living within 100 miles of an abortion clinic obtain an ultrasound at least 24 hours before having an abortion, and women living just inside this radius may be required to plan an overnight trip and shoulder the additional expense of paying for accommodations near the clinic. Texas House Bill No. 15, 82nd Leg., Regular Sess. (Tex. 2011); *see State Facts About Abortion: Texas*, GUTTMACHER INSTITUTE (2014), https://www.guttmacher.org/pubs/sfaa/pdf/texas.pdf; *see also Schimel*, 806 F.3d at 919 (recognizing that, while a "90-mile trip is no big deal for persons who owns a car or can afford an Amtrak or Greyhound ticket," such a trip may be "prohibitively expensive" for the many women seeking abortions with incomes below the federal poverty line).

These increased costs will impose a significant obstacle on many women. Indeed, the 2013 Women's Health Issues study found that the 52% of women who did not use health insurance to pay for their abortion already found it somewhat or very difficult to pay for the procedure. *See* Jones (2013), *supra*, at e175.

B. A Significant Number Of African-American Women Will Be Unable To Overcome The Substantial Obstacles Imposed By The Challenged H.B. 2 Provisions.

While the Challenged H.B. 2 Provisions impose an undue burden on all women, they will effectively preclude a significant percentage of African-American women—who are more likely to be economically disadvantaged—from exercising their constitutional right to obtain a pre-viability abortion.

African-American women are more likely than women of other races to be economically disadvantaged. In fact, the median wealth of white households is 20 times that of African-American households. Rakesh Kochhar *et al.*, *Wealth Gaps Rise to Record Highs Between Whites, Blacks, Hispanics*, PEW RES. CTR. 1 (July 26, 2011), http://www.pewsocialtrends.org/files/2011/07/SDT-Wealth-Report_7-26-11_FINAL.pdf. In 2010, compared to $1 earned by non-Hispanic white men, African-American women made only $.60 while non-Hispanic white women made $.79. *See* NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, AFRICAN AMERICAN WOMEN AND THE WAGE GAP 1 (Dec. 2015); Sarah Jane Glynn & Audrey Powers, *The Top 10 Facts About the Wage Gap*, CENTER FOR AMERICAN PROGRESS (Apr. 16, 2012), https://www.americanprogress.org/issues/labor/news/8012/04/16/11391/the-top-10-facts-about-the-wage-gap/. A study of third-quarter earnings in 2015 found that the median weekly earnings of African-American women was $608 compared with $740 for non-Hispanic white women. U.S. DEPT. OF LABOR: USUAL WEEKLY EARNINGS OF WAGE AND SALARY WORKERS – THIRD QUARTER 2015 6 (2015). African-American women are also nearly twice as likely as non-Hispanic white women to be unemployed. Maria Guerra, *Fact Sheet: The State of African American Women in the United States*, CENTER FOR AMERICAN PROGRESS (Nov. 7, 2013), https://cdn.americanprogress.org/wp-content/uploads/2013/11/SOW-factsheet-AA.pdf (reporting that African-American women had an unemployment rate of 10.5% in the second quarter of 2013 compared to 5.8% for non-Hispanic white women).

Additionally, a majority of women who have sought abortions were economically disadvantaged. A 2011

study found that poor women (those with family incomes at less than 100% of the federal poverty level) accounted for 42.4% of abortions, and women with family incomes of less than twice the federal poverty level account for 26.5% of abortions. Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 Lifetime Incidence of Abortion*, 117 OBSTETRICS & GYNECOLOGY 1358, 1362-1363 (June 2011). The same study found that abortion rates were highest for poor women across all racial groups but that poor African-American women obtained abortions at a higher rate than both poor white and poor Hispanic women and that African-American women had the highest abortion rates overall. *Id.* at 1364.

Courts may not "blind [them]selves to the fact[s]" of women's lives. *Casey*, 505 U.S. at 888-894 (relying on demographic data, incidence of domestic violence, and qualitative testimony in finding that the spousal-notification requirement constituted an undue burden); *see also Whole Woman's Health*, 46 F. Supp. 3d at 683 ("the record conclusively establishes that increased travel distances *combine* with practical concerns unique to every woman . . . to establish a *de facto* barrier to obtaining an abortion for a large number of . . . women."). When considered in the context of African-American women's historical and persistent lack of access to reproductive healthcare and the incidence of poverty among African-American women and women seeking abortion services, it is clear that a significant number of African-American women will be unable to overcome the barriers imposed by the Challenged H.B. 2 Provisions outright and thereby will be "deter[red] from procuring an abortion as surely as if [Texas] had outlawed abortion in all cases." *Casey*,

505 U.S. at 894. The Challenged H.B. 2 Provisions are therefore unconstitutional.

C. Clinic Closures Will Also Deprive African-American Women Of Critical Reproductive Health Services.

In addition to impeding African-American women from exercising their constitutional right to a pre-viability abortion, the Challenged H.B. 2 Provisions limit their access to a multitude of reproductive health services provided by the closed and threatened clinics in Texas. For example, in addition to abortion services, Whole Woman's Health offers STI testing and treatment, birth control counseling, treatment for yeast infections and urinary tract infections, pregnancy tests, IUD consultation and insertion, abnormal Pap smear treatment, and educational services. *See Gynecology*, WHOLE WOMAN'S HEALTH, http://wholewomanshealth.com/gynecology-and-family-planning.html (last visited Dec. 29, 2015).

African-American women in Texas are particularly likely to be uninsured and to rely on these clinics—including the 23 clinics that have already been forced to close—for their reproductive health services. As of 2014, a full 17% of Texans were uninsured. *State Health Facts: Health Insurance Coverage of the Total Population*, THE HENRY J. KAISER FAMILY FOUNDATION, http://kff.org/other/state-indicator/total-population. Of the 20 states that chose not to expand Medicaid coverage under the Affordable Care Act, Texas had the highest number of individuals who fell into the "coverage gap" (*i.e.*, individuals who are ineligible for publicly-financed coverage but have limited access to employer coverage and limited income to purchase

coverage on their own). Rachel Garfield & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid-An Update*, THE HENRY J. KAISER FAMILY FOUNDATION (Oct. 23, 2015), http://files.kff.org/attachment/issue-brief-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update. Of the 766,000 individuals in the coverage gap, 55% were female and 67% were people of color. *Id.* Similarly, one 2015 study found that Texas had the highest rate of uninsured for low-income households, at an appalling 27.76%, compared with the national average of 17.28%. John S. Kiernan, *2015's Rates of Uninsured by State Before & After Obamacare*, WALLETHUB, https://wallethub.com/edu/rates-of-uninsured-by-state-before-after-obamacare/4800/.

In sum, the shuttering of so many reproductive healthcare and abortion clinics in the wake of H.B. 2 will not "increase the health and safety" of women who choose to have an abortion, as its proponents claimed.[9] Quite the opposite. If left to stand, the Challenged H.B. 2 Provisions will exacerbate African-American women's inferior access to reproductive health services and compound the myriad harms they already suffer as a result.

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9. *See* Senate Comm. on Health & Human Servs., Bill Analysis, Tex. H.B. 2, 83d Leg., 2d C.S. 1 (2013) ("Moving abortion clinics under the guidelines for ambulatory surgical centers will provide Texas women choosing abortion the highest standard of healthcare."); *see also id.* ("H.B. 2 seeks to increase the health and safety of a woman who chooses to have an abortion by requiring a physician performing or inducing an abortion to have admitting privileges at a hospital.").

CONCLUSION

The Fifth Circuit's decision should be reversed.

Respectfully submitted,

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APPENDIX

APPENDIX — LIST OF *AMICI CURIAE*

In Our Own Voice: National Black Women's Reproductive Justice Agenda was founded with the goal of lifting up the voices of Black women in the ongoing policy fight to secure Reproductive Justice for all women and girls.

Utilizing three core strategies—leadership development, policy change, and movement building—In Our Own Voice seeks to provide a platform for Black women to speak for themselves and to present a proactive strategy for advancing reproductive health, rights, and justice, including the right to safe and legal abortions, at the national and state levels.

In Our Own Voice believes that Reproductive Justice is the human right to control women's bodies, sexuality, gender, work, and reproduction. That right can only be achieved when all women and girls have the complete economic, social, and political power and resources to make healthy decisions about their bodies, families, and communities. At the core of Reproductive Justice is the belief that all women have the right to have children, the right to not have children, and the right to nurture the children they have in a safe and healthy environment.

As an organization committed to policy change, In Our Own Voice primarily focuses on the issues of abortion rights and access, contraceptive equity, and comprehensive sex education. As a Reproductive Justice organization, In Our Own Voice approaches these issues from a human rights perspective and incorporates the intersections of race, gender, class, sexual orientation, and

gender identity with the situational impacts of economics, politics, and culture that make up the lived experiences of Black women in America.

The Afiya Center is a non-profit Reproductive Justice organization based in North Texas. The Aifya Center was founded in response to the absence of programs to assist marginalized women living in poverty who are at a high risk of contracting HIV/AIDS. The Afiya Center embraces the Reproductive Justice framework as the most effective means for tackling this dual epidemic.

The Afiya Center understands that the Reproductive Justice framework is the driving force behind sexual and reproductive rights for black women. By utilizing the multi-pronged framework, the Afiya Center continues to bring awareness to the connections between reproductive oppression and the increased risk of HIV transmission to women of color. Additionally, the Afiya Center believes that Reproductive Justice is a platform to create advocacy that is informed, self-actualized, and protects women's sexual and reproductive health, rights, and justice.

Access Reproductive Care-Southeast ("ARC-Southeast") is a Reproductive Justice organization based in Atlanta, GA that helps individuals and their chosen families navigate the various pathways of accessing safe, affordable, and compassionate reproductive care. ARC-Southeast believes everyone should have meaningful and adequate access to abortions. ARC Southeast provides funding for direct services, including abortions, and practical support, and engages in public advocacy.

Appendix

ARC-Southeast seeks to achieve Reproductive Justice in the South and eliminate barriers to abortion stigma and access by funding abortions, providing relevant information that resonates with people in its community, offering the readily available resources necessary for self-determination, and empowering people in its community to speak out against reproductive injustices.

Black Women for Wellness ("BWW") is a Los Angeles-based multi-generational, community-based organization committed to the well-being of Black women and girls. BWW strives to build healthy communities through education, empowerment, and advocacy. Addressing reproductive health disparities is a high priority for the organization.

For eighteen years, BWW has brought healthcare professionals, grassroots leadership, and community advocates together to share resources, knowledge and expertise as it seek solutions to health disparities in its community. BWW works to expand access to sexual and reproductive health and rights through policy advocacy, health education, and a vibrant communications plan that highlights the concerns, challenges, and experiences of African American/Black women and girls.

Black Women's Health Imperative is a national organization dedicated to improving the health and wellness of the nation's 21 million Black women and girls—physically, emotionally, and financially. Its mission is to advance health equity and social justice for Black women, across the lifespan, through policy, advocacy, education,

research, and leadership development. For 32 years, Black Women's Health Imperative has championed reproductive health for all women and informed choice for legal and safe abortions.

Black Women's Health Imperative believes quality reproductive health is a woman's right and that laws burdening abortion rights disproportionately affect poor women and women of color. Such laws restrict access to reproductive healthcare and abortions under the guise of concern for the health of women, forcing many poor women to have children they cannot afford, which makes it more likely they—and their children—will remain in poverty for the rest of their lives.

Black Women's Health Imperative believes that women have the right to decide what is best for their bodies and their families and should not be penalized because of their race or socioeconomic status.

New Voices for Reproductive Justice was founded in 2004 with the vision to achieve the complete health and well-being of Black women and girls, their families, and communities. New Voices has served and represented the interests of over 20,000 Black women and girls and women of color in Pennsylvania, Ohio, and nationally.

The mission of New Voices is to build a social change movement dedicated to the health and well-being of Black women and girls through leadership development, Human Rights, and Reproductive Justice. New Voices defines Reproductive Justice as the Human Right of all women/

people to control their bodies, sexuality, gender, work, and reproduction. Through leadership development, policy advocacy, community organizing, and culture change, New Voices amplifies the voices of Black women and girls and women of color to advance Reproductive Justice, protect abortion rights, and create access to quality and culturally appropriate healthcare.

SisterLove, Inc. is on a mission to eradicate the impact of HIV and sexual and reproductive oppressions upon all women and their communities in the United States and around the world. SisterLove envisions a world in which everyone can live in human dignity with equal protections regardless of illness, disability, race, sex, class, sexual or gender identity or other cultural, social, political, economic or geographic distinctions.

SisterLove is a 25 year-old reproductive justice organization with a focus on sexual health and prevention/care, including HIV, STIs, unintended pregnancy and violence. As an active collaborator and partner with a diversity of networks, coalitions and movement-building organizations, SisterLove has continued its commitment to ensuring that the human rights framework of liberty, justice and dignity is the core element of any social change effort to protect and advance the sexual and reproductive health and rights of women and their families. Armed with the resilience and determination of the women it serves, SisterLove works at the many dangerous intersections that impact Black women's lives, and works to change the policy frame from defending women's choices to asserting women's agency to make decisions that are best for themselves and their families.

Appendix

SisterReach, founded in October 2011, is a Memphis-based non-profit organization supporting the reproductive autonomy of women and girls of color, poor women, and rural women as well as their families through the framework of Reproductive Justice. The organization's mission is to empower women and girls to lead healthy lives, raise healthy families, and live in healthy communities.

SisterReach provides comprehensive reproductive and sexual health education to women and teens, and advocates at local and state levels for public policies that support the reproductive health and rights of all women and youth. SisterReach utilizes community dialogues, civic engagement, and inter-faith community engagement strategies to expand new relationships among stakeholders.

SisterSong – The National Women of Color Reproductive Justice Collective is a Southern-based national membership organization formed in 1997 by 16 organizations of women of color from four minority-communities (Native American, African American, Latina, and Asian American) who recognized that their constituents have the right and responsibility to represent themselves and their communities, and the equally compelling need to advance the perspectives and needs of all women of color. SisterSong's mission is to strengthen and amplify the collective voices of Indigenous women and women of color to achieve Reproductive Justice by eradicating reproductive oppression and securing human rights. SisterSong's purpose for nearly 20 years has been to build an effective network of individuals and

organizations to improve institutional policies and systems that impact the reproductive lives of marginalized communities.

As the National Women of Color Reproductive Justice Collective, SisterSong has defined Reproductive Justice as the human right to have children, not have children, and parent children in safe and healthy environments. Over the years, SisterSong expanded its definition of Reproductive Justice to include the human right to bodily autonomy from any form of reproductive oppression. SisterSong also supports the expansion of Reproductive Justice into other social justice movements and is committed to training the next generation of feminists/activists on the evolution of the Reproductive Justice framework, centering on The International Declaration of Human Rights. As a national collective, SisterSong's purpose is to create spaces for movement leaders and organizations to engage in continual professional and organizational development toward the sustainability and longevity of Reproductive Justice work and to provide a platform for the movement to work together collaboratively on shared policy and advocacy goals for the advancement of Reproductive Justice.

SPARK Reproductive Justice NOW! is a Reproductive Justice organization based in Atlanta, Georgia, working to shift policy and culture to protect and expand access to the full range of family planning options, abortion access, and sexual and reproductive health education for Black women, women of color, and Queer and Trans youth of color in the state of Georgia and the South. SPARK envisions a world

in which economic, social and cultural equity, restorative justice, body autonomy, and comprehensive reproductive and sexual freedom exist; and where all people are empowered, valued, and able to make decisions about their communities, families, and lives.

SPARK believes that in order to achieve reproductive justice, it must first respond to the immediate needs of its communities, including access to information, education, healthcare, comprehensive sexual and reproductive health services, safe spaces, and each other.

URGE: United for Reproductive & Gender Equity is an organization founded in 1992 with chapters throughout the country dedicated to developing young leaders, strengthening the progressive community, and building power to advance gender equity, sexual health, and reproductive justice. URGE envisions a world where all people have agency over their own bodies and relationships, and the power, knowledge, and tools to exercise that agency. URGE builds this vision by engaging young people in creating and leading the way to sexual and reproductive justice for all.

URGE believes that young people, and particularly young people of color, face exponentially more barriers to accessing their constitutionally protected healthcare, including abortion services. URGE represents a diverse constituency of young people in Texas who are articulating a vision in which everyone has the power, resources, and access to create families when and how they want.

Appendix

Women With a Vision, Inc. ("WWAV") is a New Orleans-based non-profit, founded in 1989 by a grassroots collective of African-American women in response to the spread of HIV/AIDS in communities of color. The mission of WWAV is to improve the lives of marginalized women, their families, and communities by addressing the social conditions that hinder their health and well-being. WWAV accomplishes this through relentless advocacy, health education, supportive services, and community-based participatory research. Major areas of focus include Sex Worker Rights, Drug Policy Reform, HIV Positive Women's Advocacy, and Reproductive Justice outreach.

WWAV envisions an environment in which there is no war against women's bodies, in which women have spaces to come together and share their stories, in which women are empowered to make decisions concerning their own bodies and lives, and in which women have the necessary support to realize their hopes, dreams, and full potential. WWAV uses Reproductive Justice as a way of acknowledging and addressing the complex realities of the lives of the women in its communities. For WWAV, Reproductive Justice is about placing the needs of the women front and center. The populations WWAV works with are often not visible within the health system and kept from services and access to the things they need to lead healthy lives. WWAV provides navigator services connecting women in its community to women's health, sexual, and reproductive services.